DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4024A (Rev. 12/05)

STATE OF WISCONSIN
Bureau of Community Health Promotion
WIC Program, Federal Reg. 246

WIC MEDICAL NUTRITIONAL PRESCRIPTIONS / CLINICAL DATA
PREGNANT, BREASTFEEDING AND NONBREASTFEEDING POSTPARTUM WOMEN

Completion of this form is voluntary. Personally identifiable information is used to determine WIC services (e.g., certification/enrollment and food package issuance) and may be disclosed to others only as allowed by state and federal laws.

INSTRUCTIONS: To provide clinical data (to facilitate WIC enrollment), complete the Clinical Data section. To prescribe a WIC-approved medical nutritional product, complete Prescription sections 1, 2 and 3. Indicate additional concerns or relevant obstetrical history in the Nutrition/Health Concerns/Relevant Obstetrical History section, as appropriate.

Patient's First and Last Name _____ Birthdate (MM/DD/YY) _____

CLINICAL DATA

Pregnant and Postpartum Women: Current Weight _____ Current Stature _____ Date taken _____

Hct ____% and/or Hgb ____ mg Date taken _____ Vitamin/Mineral Rx _____

Pregnant Women: E.D.D. _____ Current weeks gestation _____ Prepregnancy weight _____

Postpartum Women: Delivery date _____ Prepregnancy weight _____ Weight gained _____

If not on WIC prenatally, prenatal nutrition-related health problems or relevant obstetrical history:

- ☐ Gestational Diabetes
- ☐ Pregnancy-Induced Hypertension
- ☐ Hyperemesis Gravidarum
- ☐ Anemia
- ☐ Food allergy or intolerance: ____ _____
- ☐ Infectious disease: _____ _____
- ☐ Chronic disease: _____ _____
- ☐ Other nutrition-related health problem: _____

PRESCRIPTION (Complete 1, 2 and 3; all are required for WIC provision of the prescription.)

1. Medical Nutritional prescribed:

Ensure: ☐ Regular ☐ Fiber ☐ Glucerna ☐ Glucerna OS ☐ High Calcium ☐ High Protein ☐ Light ☐ Plus ☐ Plus HN

Boost: ☐ Regular ☐ Fiber ☐ Plus ☐ High Protein ☐ Breeze

2. Intended length of use: Number of months _____

3. Medical diagnosis and ICD-9 code justifying the above prescription:

- ☐ Hyperemesis Gravidarum (643)
- ☐ Gestational Diabetes (648.2)
- ☐ Multifetal gestation (651)
- ☐ Low maternal weight gain (646.8)
- ☐ Prenatal weight loss (783.2)
- ☐ Intestinal Malabsorption (579.9)
- ☐ Other diagnosis, with ICD-9 code (required): _____ _____

NUTRITION/HEALTH CONCERNS/RELEVANT OBSTETRICAL HISTORY:

SIGNATURE - Health Care Provider _____ Date Signed _____
(Physician, Physician Assistant or Advanced Practice Nurse prescriber signature is required for prescriptions of the above formulas or medical foods.)

Printed Name of Health Care Provider _____

Medical Office/Clinic _____

Address _____ Telephone _____

LOCAL WIC PROJECT: